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Family Health Dataline

IN THIS ISSUE:

- We introduce Healthy Families, a program to identify families at risk of having children with poor health outcomes and providing intensive paraprofessional home visitation services.
- Currently, 265 sites in 37 states provide Healthy Families services.
- Alaska has eight Healthy Families programs, called Healthy Families Alaska, in seven different areas.
- Healthy Families Alaska provides interventions specific to the needs of individual families but for each family collects similar data elements for outcome measurements.
- We anticipate completion of initial data analysis within 6 months.

Healthy Families Alaska

Introduction

Recent studies have identified risk factors for children at risk of poor health outcomes including child abuse and neglect, developmental delay, poor growth, and lack of immunizations. Healthy Families Alaska (HFAk) aims to promote healthy child outcomes and prevent child maltreatment. Many of the identified risk factors are common among Alaskan children. For example, poverty and a broken family may contribute to poor child health. During 1990, one in five Alaskan children under the age of five lived in poverty and 22% of Alaskan children under 18 years of age lived in a single parent family.[1,2]

The consequences of high-risk environments are apparent when health statistics for Alaskan children are examined. A July 1997 report revealed that Alaska had the second highest injury death rate in the US among children less than 10 years of age during 1990-1994[3] and that one-third of these deaths were preventable. Additionally, in 1996, only 73% of Alaska's two year olds had received all age-appropriate vaccines compared to the national average of 78%.[4] Finally, Alaska has alarming rates of reported child abuse and neglect. Child abuse case reports were made for 58.2 out of 1,000 children under age 18 for the year 1995 and 16.1 per 1,000 were substantiated.[5]

To address the problem of poor child health at, perhaps, its primary cause—a poor social environment and family disintegration—the National Committee to Prevent Child Abuse supported widespread use of a program first developed in Hawaii, known as Healthy Start. This program involved identification of at-risk children followed by intensive home visitations from workers to provide family support. In response, task forces and evaluation teams have been formed in many states to look into the use of home visitation to prevent harmful child outcomes.

Since 1992, Healthy Families America (HFA), has established programs at 265 sites in 37 states plus the District of Columbia based on this approach, including Alaska with Healthy Families Alaska (HFAk). Currently, eight sites in Alaska have initiated HFAk, including population-based programs in Juneau, Kenai, Bethel, South Fairbanks, the Mat-Su Borough, the Bristol Bay Region, and a portion of the Mt.View neighborhood in Anchorage as well as a program to serve the Alaska Native/American Indian population in Anchor-

age. Each HFAk program site is part of a larger nonprofit organization in that community, with the exception of Kenai, which is part of Public Health Nursing. A total of 311 families were being served by these programs as of June 30, 1997.

Background

Healthy Families Alaska

HFAk is grounded in the belief that community-specific interventions have the best hope of achieving the goal of improved child health. The goals of HFAk include:

1. Systematic assessment of the strengths and needs of new parents and referral to community services as needed.
2. Enhancement of family functioning by: building trusting, nurturing relationships; teaching problem-solving skills; and improving the family's support system.
3. Promotion of positive parent-child relationships.
4. Promotion of healthy childhood growth and development.[6]

HFAk hopes to achieve these goals through implementation of a specific set of home visitation elements which have been identified as critical by the Hawaii Healthy Start Program and the National Committee to Prevent Child Abuse. These elements are critical for the following reasons. Research has demonstrated that they are common to home visitation programs for new parents which achieve desired outcomes, including preventing child abuse and neglect; they assure quality; and allow for flexibility in program implementation. The critical elements of effective home visitation programs are:

1. Initiation of services prenatally or at birth.
2. Use of a standardized assessment tool to identify families in need of services.
3. Use of positive, persistent, outreach efforts to build family trust.
4. Provision of intensive and long-term services.
5. Provision of culturally competent services.
6. Focusing services on support of the parent(s) as well as parent-child interaction and child development.
7. Linking families to a medical provider and other needed services.
8. Provision of services by staff with limited caseloads.
9. Selection of home visitation providers based on their personal characteristics and their skills to do the job.
10. Training providers in areas such as: cultural competency, substance abuse, reporting child abuse, domestic violence, drug exposed infants, and available services in their community.
11. Provision of intensive training to providers so that they understand the essential components of family assessment and home visitation.
12. Provision of ongoing effective supervision for providers.[7]

Enrollment into the Healthy Families Alaska Program

Enrollment into HFAk begins with a systematic assessment of all births in each of the eight geographic areas served. Prenatally, or up to two weeks after delivery, the HFAk-trained Family Assessment Worker provides a screening questionnaire to the primary care giver (usually the mother). Families identified as at-risk are offered an in-depth assessment that is modeled after the Kempe Family Stress Checklist. Families identified at highest risk are offered enrollment in HFAk. A paraprofessional home visitation provider contacts clients who elect to enroll in the program within a few days of their assessment. This begins the process of intensive home visitation that characterizes the HFAk initiative.

Service Provision

HFAk seeks to find the most easily accessible antecedent event in the causal chain leading to poor child

Case A

Jane experienced abuse as a child and, beginning at 6 years of age, lived in a series of foster homes and youth facilities from which she frequently ran away. She had abused various substances, engaged in violent behavior, and dropped out of high school with only vague plans for returning. She enrolled in a Healthy Families program near the end of her pregnancy, at age 15. The Healthy Families program worked with Jane to develop a plan to finish high school, become emancipated, get a job and apartment. They promoted positive parent-child interaction by reinforcing positive parenting, role modeling, and referring Jane to a parent support group. During the ensuing 18 months, Jane has received her high school equivalency diploma, obtained a driver's license, kept a job, bought a car, and made plans to attend clerical skills classes. Additionally, she now lives in a semi-independent foster care setting. Her daughter is a happy, healthy, 18 month old child who is up to date on her immunizations, on target with growth and development and has had not been reported for abuse or neglect.

Case B

As a child, Sarah experienced abuse from a mother and stepfather who took illicit drugs and drank alcohol to excess. She was homeless when she went into labor four months prematurely in a hotel room while using crack cocaine. Because the child's urine tested positive for cocaine, State intervention was initiated. At the mother's request, however, a judge allowed her to keep her child contingent upon enrolling in Health Families in the spring of 1995. The Family Support Worker referred Sarah to a shelter for women and assisted her with acquiring subsidized housing, bus passes, and food. She also provided support while Sarah completed a year of outpatient drug rehabilitation (during which Sarah had consistently negative drug screens). To date, Sarah has returned to school and graduated at the top of her class, maintained full-time employment, and bought a car. Her first child is now 28 months old with age-appropriate growth, development, and immunization status. There has not been any other DFYS involvement, and Sarah recently had a second baby who was born drug free. Both children are growing and thriving.

health and social outcomes. While many of the precipitators of poor child outcomes are common among families–including poverty, stress, anger, and neglect–the specific events leading to these common pathways will differ widely among different families. Consequently, home visitation providers will deliver a variety of services which will be directed towards the needs of the individual family.

For example, a single parent may live in poverty because of unemployment. Unemployment may result from an inability to find daycare or access job placement services because of a lack of skills or time. In this instance the home visitation provider will attempt to find daycare for the child and teach the parent the skills necessary to locate appropriate job placement agencies. In another example, a parent might neglect their child because of a drug addiction. In this instance the home visitation provider will find a suitable drug rehabilitation program and provide social support while the parent attends the program.

Outcome Measures

Individual HFAk programs together with the Section of Maternal, Child and Family Health have developed common outcome and process evaluation measures to determine program effectiveness. The following is an overview of the four categories of evaluation measures developed to assess program progress.

1. **Parenting Outcomes** - these are measured using the Parenting Stress Index and the Home Observation for Measurement of the Environment which are standardized instruments commonly used nationally by Healthy Families Programs. Examples of sub scales include measures of depression, social isolation, attachment, parenting stress, and parent child interaction. The expectation is that 90% of mothers or primary care givers will maintain or improve their scores at specified ages of the target children.
2. **Child Development Outcomes** - this is being measured using a standardized growth and development screening tool, the Ages and Stages Questionnaire. The expectation is that 100% of target children will be screened and 100% who do not meet their milestones, or for whom there is a concern, will be referred for follow up services.
3. **Utilization of Community Resources** - this outcome is measured by progress in the following areas: postpartum visits occurring within 2 months postpartum; client access to a primary care provider; for mothers or primary care givers who are in mental health or substance abuse treatment, maintenance of their treatment programs; for mothers or primary care givers who have identified themselves as victims of partner abuse, being able to articulate their safety plans; a delay of at least two years before the mother or primary care giver has another child; for mothers or primary care givers, completion of or enrollment in high school or progress towards acquiring a GED; and participation in employment preparation and career counseling.

Case C

Rhonda was 18 years old, pregnant, and in jail for assault when she enrolled in the Healthy Families Program. She had a history of living in foster care, previous incarceration, and substance abuse. Plans were made to have the state assume custody of her child at birth, potentially signaling the beginning of another broken family as well as a cycle of State dependency. Rhonda, however, elected to keep her child and enroll in Healthy Families. The Healthy Families program connected Rhonda with community agencies, support groups, taught her how to problem solve, advocated on her behalf and developed goals and plans for the future. The program was consistent, they were there even when Rhonda was difficult to be around, and showed that they cared for her and her baby, a level of commitment that Rhonda had never experienced. Subsequently, Rhonda has maintained custody of her child, worked toward completion of her high school equivalency examinations, acquired a part-time job which has allowed her to move into a safer neighborhood, and purchase a car. Her child has age-appropriate growth and development and immunization status. No substantiated reports of abuse or neglect have occurred.

4. **Reports of Child Abuse and Neglect** - this outcome is measured by assessing out of home placements, substantiated incidents of abuse and neglect of target children, and evaluating differences between families who have had previous Division of Family and Youth Services (DFYS) involvement, those who have not, and those who are first time parents. The expectation is that 95% of target children will not experience abuse or neglect.

We anticipate that we will have completed preliminary data analysis of these outcomes within 6 months.

Submitted by Jeff Powell

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